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ABSTRACT

The mail survey research method was used to determine the comparative impact of mandatory and voluntary continuing education systems for relicensure on the performance of health care professionals. Of 1,901 questionnaires mailed to dental hygienists in Wisconsin and Minnesota, 63 percent (1,201) were returned. Supervising dentists and dental hygiene patients also participated. Several types of evaluative dimensions were used to assess the practitioner's performance in each system: satisfaction with the quality of care, cognitive achievement, general performance, technical competence, and interpersonal behavior. Performance ratings were submitted by the health care providers themselves, their supervisors, and the recipients of care. Analysis of the resulting data demonstrated no practical significant difference in performance between the study populations practicing under mandatory and voluntary continuing education systems. Overall, professional performance and the quality of care provided were reported to be highly satisfactory. Of their own accord, most of the responding practitioners had a propensity toward lifelong learning. (YLB)

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A COMPARISON BETWEEN MANDATORY AND VOLUNTARY CONTINUING EDUCATION ON PROFESSIONAL PERFORMANCE*

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A COMPARISON BETWEEN MANDATORY AND VOLUNTARY CONTINUING EDUCATION ON PROFESSIONAL PERFORMANCE

Although continuing professional education (CPE) is recognized by most health care providers as a means to keep updated, attitudes toward mandating continuing education requirements for relicensure are not unanimous. Arguments in favor of such legislation view personal responsibility as a weak motivational factor which does not encourage individuals to take advantage of continuing education opportunities (1,2). Others contend that there is no measure short of compulsion through licensing mechanisms to pursuade professionals to attend continuing education activities (3). In contrast, opponents of mandatory continuing education assert that no such legislation will significantly change incompetent practitioners into quality care providers (4). And still others emphasize the importance of intrinsic motivation for learning to occur (5,6).

In spite of the fact that it is highly controversial, mandatory continuing education (MCE) is being treated more and more frequently as a type of quality assurance mechanism (7). This trend is based on the assumptions regarding its effects which are: if exposed to meetings, courses, or other educational activities, the professional's existing knowledge and skills will be reinforced while new knowledge and skills are acquired which, in turn, will lead to quality patient care (8,9). Although continuing education is assumed to enhance professional competence, the effectiveness of CE programs varies considerably. Some studies indicate an increase in knowledge, but no change whatsoever in professional performance (11-12); others demonstrate performance improvements in accordance with program goals either through performing skills exactly as learned or with modifications thereof (13-15). As a result of this variance in program outcomes, much discussion continues to center around the quality of CE programs, especially the educational techniques employed and the relevance of programs to participants' practice needs (16,17).

In addition to the perceived necessity of continuing education as a bulwark against the rapid obsolescence of professional competence, increased government involvement in health care delivery and the challenge arising from the increasing interests in consumerism also have created mounting pressures toward compulsory continuing education requirements for periodic recredentialing (18-20). As a result, many states have established mandatory continuing education requirements as a condition for relicensure in the public's interest (21). Yet, the effects of MCE have not been clearly demonstrated since the literature provides little evidence of studies which compare the general impact of mandatory continuing education as contrasted with voluntary continuing education on professional practice and the quality of care (22-24).

Therefore, even though the behavioral outcomes of continuing education vary considerably, the current issue is not whether quality continuing education is worthwhile, but rather whether continuing education should be a legislated prerequisite for license renewal based on tenuous assumptions or remain as a traditionally personal and professional responsibility.

METHOD

To determine the comparative impact on professional performance between health care professionals practicing under mandatory and voluntary continuing education systems for relicensure, the mail survey research method was utilized. Several types of evaluative dimensions were employed to assess the practitioner's performance in each system: (a) satisfaction with the quality of care, (b) cognitive achievement, (c) general performance, (d) technical competence, and (e) interpersonal behavior. Performance ratings were submitted by the health care providers themselves, their supervisors and the patient-recipients of care.

Data Source

Dental hygiene practitioners from two comparable midwestern states were eligible for participation in this study. The state of Minnesota has mandated continuing education for its dental professionals since 1969 (25), while its neighboring Wisconsin has no similar legislative requirement for license renewal. In October 1983, the names and addresses of half of the hygienists in each state were selected systematically, after a random start, from complete listings commercially available in each state. An 80-item survey instrument was mailed to 956 Wisconsin hygienists and 945 Minnesota hygienists. Besides pertinent demographic information, this form provided self-assessments of the hygienist's general, technical and interpersonal performance as well as the hygienist's perceptions regarding the quality of care she or he provides. A cognitive measure of performance was included in the survey in the form of a 20-item stratified random sample of dental hygiene national board questions. Lastly, data related to the hygienist's continuing education history and continuing education opinions were solicited. A postage paid reply envelope was provided for the hygienist's convenience as well as for purposes of facilitating the response.

A sample of supervising dentists was generated from each state as responding hygienists submitted their dentists' names, addresses and telephone numbers via the last page of the dental hygiene questionnaire. Subsequently, each dentist was mailed a survey packet which was nummerically coded to correspond with the appropriate hygienist. This packet included, in part, a 23-item evaluation instrument to assess his/her dental hygienist's general, technical and interpersonal job performance, and the dentist's satisfaction with the quality of dental hygiene care rendered. In addition, patient questionnaires were enclosed in the dentist's survey packet. Each dentist was requested to arrange for the administration of the 12-item survey instruments to five adult patients who had just completed treatment with the hygienist. Patients assessed their hygienist's general and interpersonal performance, and expressed their level of satisfaction with the quality of care received. When patients completed their evaluations, and for purposes of confidentiality, sealed them in the blank envelopes provided, the surveys were returned together with the dentist's questionnaire in a prepaid reply envelope.

Follow-up procedures consisted of one reminder letter sent to hygienists who had not responded three weeks after the initial mailing. To encourage

participation by those dentists who had not yet replied, two follow-up telephone calls were scheduled at two-week intervals after the assessment packets were mailed. Additionally, to increase the response rate, it should be noted that on the initial mailing, each hygienist and dentist received a "token of appreciation" in the form of a crisp one-dollar bill attached to the accompanying cover letter.

Reliability

Scale and test reliabilities for internal consistency were assessed by Cronbach's coefficient alpha (26). All four of the supervising dentist's scales achieved coefficients of .80 or higher. Of the three patient evaluation scales, one showed a reliability coefficient of .66, while the others exhibited coefficients equal to .77. Reliability coefficients for the hygienist's self-assessment scales were .60 or greater, with the exception of the general performance scale. Although the reliability of this scale (.54) was less than optimal, it was considered adequate for the purposes of this study. The continuing education opinion scale demonstrated a reliability coefficient of .87.

RESULTS

Of the 1,901 questionnaires mailed to dental hygienists in Wisconsin and Minnesota, 63% (1,201) of the study population, including practicing and nonpracticing hygienists, responded. Seventy-four percent of the practicing hygienists in Wisconsin (330/444) and Minnesota (325/440) provided the names, business addresses and telephone numbers of their supervising dentists. Overall, 72% of the 655 dentists contacted in Wisconsin (245/330) and Minnesota (229/325) answered the supervising dentist questionnaire. Furthermore, in Wisconsin 85% (208/245) of the responding dentists cooperated by including their patients in the study. Likewise, 89% (203/229) of the responding Minnesota dentists also solicited their patients' participation. As a result, a total of 2,013 dental hygiene patients was achieved between Minnesota (999) and Wisconsin (1,014).

Satisfaction with the Quality of Care

Using items based on a five-point scale format, dentists and patients were asked how satisfied they were with the quality of care provided by their hygienists and whether they would (a) as in the dentist's case, rehire the same hygienist if the circumstance ever presented itself, or (b) in the patient's case, be willing to be treated by the same hygienist during his or her next dental check-up. Through analysis of covariance procedures, the results indicated that dentists in both states were satisfied equally with the quality of care provided by their hygienists, but that the two groups of patient samples significantly differed ($F = 6.06$, $p < .01$) in their responses concerning the quality of dental hygiene care received. However, the statistically significant difference between patient responses should be tempered by the fact that the amount of variance accounted for in explaining the effects as computed by omega squared was a mere 1.2%. From a practical significance perspective, then, this reasonably implies that patients in both states rated their hygienists equally with regard to the

quality of care rendered by their respective hygienists. Moreover, the quality of care was assessed very positively with a mean score of nine out of ten points for both groups of dentists and both groups of patients. Thus supervising dentists and patients appeared to be highly satisfied with the quality of care rendered by their hygienists. And, if the circumstance would ever present itself, the greater majority of dentists (95%) replied that they would rehire the same dental hygiene practitioners. Patients also were willing to be treated by the same hygienists on the next check-up. Approximately 99% of the patients indicated a high level of receptiveness toward their hygienists.

In comparing the dental hygienists' ratings of satisfaction with the quality of care with their supervising dentists' satisfaction ratings, no practical significant differences were shown to exist. Similarly, when comparisons were made between the hygienists' perceptions of how satisfied they believed their patients were with the care received and the patients' reports of satisfaction, no significant difference was evident statistically.

Cognitive Measure of Competence

As a competency assurance measure, the Minnesota Board of Dentistry permits hygienists to complete the Dental Hygiene National Board Examination in lieu of the required continuing education units for relicensure (27). A similar concept was employed in this study: To measure dental hygiene professional performance under mandatory and voluntary continuing education systems for relicensure, the second evaluation dimension consisted of a stratified random sample of 20 items selected from the most recently released national board exam. Of the responding hygienists, a total of 1,195 (99%) completed the multiple-choice test. More specifically, 602 of the 603 hygienists in Wisconsin and 593 out of 598 Minnesota hygienists participated in the written measure of professional competence.

Analysis of covariance resulted in a statistically significant difference ($F = 10.09$, $p < .002$) between the two groups of hygienists. However, from a practical significance perspective, a negligible omega squared (.0076) and a lack of significant differences between the mean test scores (12 out of 20 points for both states), suggest that the hygienists in the voluntary continuing education state demonstrated performance on the written examination comparable to that of their colleagues in the mandatory continuing education state.

General Performance Assessments

The third evaluative dimension was based on the general professional performance of dental hygienists. Supervising dentists and hygienists responded to scale items which focused on the supervising dentist's confidence in the hygienist's work and the hygienist's knowledge of clinical problems, interpersonal relations, and work quality. Analysis of covariance demonstrated no significant difference between the dentists' replies concerning their hygienists' general performance. In both states, the supervisors appeared to be favorably impressed with their dental hygienists' general performance.

Similar to the results obtained from their supervisors, analysis of covariance produced no significant difference between the two groups of hygienists regarding their self-assessments of general performance. In addition, the overall mean self-assessment rating score was equivalent to that of the supervising dentists.

Consistent with data collection procedures for dentist and hygienist ratings, dental hygiene patients in both mandatory and voluntary continuing education states appraised their hygienists' general performance. Items comprising the patient rating scale provided a description of the patients's (a) confidence in the hygienist's work, (b) assessment of the hygienist's attempts to be gentle, (c) perception of the degree to which the hygienist interpersonally relates in comparison to other health care professionals, and (d) satisfaction with the length of the appointment time. Analysis of covariance was conducted to determine whether patients in each state would evaluate their hygienists' general performance differently. As a result, patient ratings ascribed to hygienists practicing under mandatory and voluntary continuing education relicensure systems revealed no significant difference. Furthermore, under both relicensing conditions patients' general performance evaluations were judged to be highly supportive.

Technical Competence Assessments

As the fourth evaluative dimension, supervising dentists and dental hygiene practitioners appraised the hygienist's performance of technical procedures during the regular prophylaxis appointment. Assessment items regarding this preventive health care treatment were adapted from standards for clinical practice as developed by the American Dental Hygienists' Association (28). Examples of such items included functions related to the accuracy of radiographic techniques, thoroughness in removing calcareous deposits from the tooth's surface, the comprehensiveness of recording oral health conditions, and so on.

Because supervising dentists regularly conduct detailed oral examinations for patients who have received dental hygiene care, their assessment of the hygienist's technical performance carries considerable weight. To determine whether there were any rating discrepancies between dental hygiene supervisors in Minnesota and Wisconsin, analysis of covariance was performed on the responses submitted. The outcome demonstrated no significant difference between dentists' technical performance ratings of hygienists practicing under mandatory and voluntary continuing education systems for relicensure. Data analysis further showed that the supervisors attributed their hygienists' performance with a high degree of clinical competence.

Dental hygienists practicing under the two continuing education systems evaluated their technical performance using the same rating scale as did their supervisors. When analysis of covariance was performed on the scale data, no significant difference was evidenced between the two groups of hygienists in their self-assessment of clinical practice performance. Also, the self-assessed ratings for both groups of hygienists closely resembled the appraisals submitted by their supervising dentists.

Interpersonal Performance Ratings

Of equally important interest among factors associated with the performance of health care professionals is the provider's efforts in creating a satisfactory practitioner-patient relationship. Thus, the fifth evaluative dimension in this study was concerned with the assessment of interpersonal behavior in terms of dental hygiene performance in the clinical setting. Supervising dentists and their dental hygienists completed rating scales based on items adapted from practice standards recommended by the American Dental Hygienists' Association. The scales included items which focused on the percentage of cases in which the hygienist (a) responds appropriately to the patient's verbal and nonverbal expressions of concern, (b) allays the patient's fears, (c) explains clinical procedures being performed, (d) appropriately conducts the patient's health history, and (e) provides instruction in home health care procedures.

Analysis of covariance was performed on both the dentists' and hygienists' ratings. No significant difference was detected between the dentists' assessments of their hygienists' interpersonal behavior. Consistent with the other performance ratings submitted by these dentists, the responses to this scale also exhibited favorable attitudes toward the hygienists' interpersonal abilities. However, the hygienists' self-assessments of interpersonal behavior showed a statistically significant difference ($F = 13.12$, $p < .001$) between dental hygienists practicing under mandatory and voluntary continuing education systems. To determine the magnitude of the effect, an omega squared was computed. Only 1.3% of the variance in the hygienists' ratings could be attributed to the type of CE system. Furthermore, the mean scale difference between the two groups of dental hygiene clinicians, whose ratings coincided with those of their supervisors, was negligible. Practically speaking, the data reasonably suggest that under both continuing education conditions, the dental hygiene self-assessments were equivalent.

Dental hygiene patients in Minnesota and Wisconsin also responded to a rating scale designed to evaluate their hygienists' interpersonal behavior during their dental check-up appointments. Items on this scale referred to the hygienist's (a) efforts in responding to patients' questions, (b) explanations of clinical procedures being performed, and (c) efforts in providing information on home oral health care. Although analysis of covariance suggested dissimilar group assessments ($F = 10.45$, $p < .001$), the results of an omega squared procedure pointed out that only 2.25% of the variance was accounted for in explaining the patients' ratings. Thus from a practical significance perspective, it could be argued that patients' evaluations between states paralleled each other. In addition, patients' responses indicated that they were quite pleased with the interpersonal behavior of the dental hygienists who provided their oral health care services.

Continuing Education (CE) Profile

Of the practicing respondents, approximately 84% in Wisconsin and 96% in Minnesota participated in continuing education activities during the last

12 months. Chi-square analysis revealed significant differences between these two groups of hygienists regarding the number of continuing education programs attended and hours accumulated. As expected, hygienists licensed under the mandatory continuing education system participated in more CE programs and attained more CE hours than did their colleagues in the voluntary continuing education system. Yet, the performance ratings across all measures suggested that there were no practical significant differences between the two groups of hygienists. This may be explained, in part, by correlational analysis which revealed low coefficient values ranging from .10 to .20 between the performance assessments and continuing education program attendance.

A slight difference was seen between the Wisconsin and Minnesota hygienists in their ranking of the top three types of continuing education activities that they believed contributed most to their professional competence. Hygienists in both states indicated that CE courses provided by a dental or dental hygiene school enhanced their professional performance the most. Ranked second most important by Minnesota hygienists was CE programs offered by local professional organizations; whereas, Wisconsin hygienists ranked consultation with other hygienists in second place. Consultation with other hygienists was the third most important activity in the improvement of their competence as reported by Minnesota hygienists. Wisconsin hygienists specified the reading of journals as the third most important contributor to their performance. It is apparent from these responses that regardless of rank order, both groups of hygienists tended to rate CE programs and verbal exchanges with colleagues as paramount in their professional development.

Lastly, it is gratifying to note that the most popular reason for attending continuing education activities, irrespective of external requirements, was personal interest.

DISCUSSION

Unlike other research studies in continuing education which have reported on the outcomes of specific programs, this study investigated the impact of continuing professional education as a whole. Of primary interest was whether there was a difference in professional performance between practitioners rendering health care services under mandatory and voluntary continuing education systems for relicensure. Performance was assessed through means of a standardized written exam, practitioner self-evaluation, supervisor appraisals and patient ratings. The evaluative dimensions included cognitive achievement; general, technical and interpersonal performance; and satisfaction with the quality of care provided. Analysis of the resulting assessment data demonstrated no practical significant differences in performance between the study populations practicing under mandatory and voluntary continuing education systems. Overall, professional performance and the quality of care provided were reported to be highly satisfactory.

Although mandatory continuing education legislation increases the individual's participation in continuing education activities, this study also revealed that, of their own accord, most of the responding practitioners had a propensity toward lifelong learning and a personal need to collaborate with colleagues for professional development. However, even though a high rate of CE participation was reported, the relationship between CE attendance and performance ratings was relatively weak. This obviously suggests that regardless of legal requirements, CPE plays a small role as it relates to professional performance in practice. Nonetheless, CPE was hailed as a valuable activity among the majority of respondents.

Considering the results of this study, rather than expending valuable time, funding and energy on the legislative and administrative tasks associated with mandating continuing education for relicensure, it would seem more productive to redirect these resources toward providing quality, relevant, well-marketed and accessible programming in conjunction with the application of a variety of effective adult education techniques. An action plan with such components would be a better way to increase participation, enhance the value of CE and maybe even increase the probability of improving professional performance in the consumer's interest.

Mandatory continuing education for relicensure continues to proliferate for a variety of professions as a means of ensuring competence for the public's welfare (28). Certainly the movement of various professional groups toward encouraging their members to engage in voluntary continuing education should be applauded. However, if professions legislate continuing education requirements as a relicensure condition, they owe their members substantive proof that it ensures competence. Thus additional studies are needed to generate information which would contribute to a greater understanding of MCE as it compares to voluntary continuing education and assist policy makers in deliberating legislative issues concerning mandatory continuing education requirements for health care professionals. Hopefully, in the interim, the proponents of mandatory continuing education will begin to re-examine their arguments for such legislation in light of other feasible options in their search for quality assurance mechanisms.

References

1. Egelston, E. M. (1974). Continuing education: A requirement for professional membership or a necessity for relicensure. Journal of Continuing Education in Nursing, 5(3), 12.

2. McGriff, E. P. (1972). A case for mandatory continuing education in nursing. Nursing Outlook, 20(11), 712-713.

3. Moxley, J. H. (1969). Legislation and social pressures for continuing education. Journal of the American College of Dentists, 36(3), 164.

4. Ohliger, J. (1981). Dialogue on mandatory continuing education. Lifelong Learning: The Adult Years, 4(10), 5.

5. Libby, G. N., Weinswig, M. H., & Kirk, K. W. (1975). Help stamp out mandatory continuing education. Journal of the American Medical Association, 233(7), 797-799.

6. Bigge, L. (1971). Learning theories for teachers. New York: Harper & Row Publishers, Inc.

7. Adelson, R., & Watkins, F. (1978). Quality and perceived usefulness and utilization of continuing dental education: A response. Journal of the American College of Dentists, 45(2), 102-110.

8. Clark, K. M., & Dickinson, G. (1976). Self-directed and other-directed continuing education: A study of nurses' participation. Journal of Continuing Education in Nursing, 7(4), 16-24.

9. Smith, R. (1981). Quality in continuing pharmaceutical education. Lifelong Learning: The Adult Years, 4(10), 4, 5, 24.

10. Gonnella, J. S., Goran, M. J., Williamson, J. W., & Cotsonas, N. J. (1970). Evaluation of patient care: An approach. Journal of the American Medical Association, 214(11), 2040-2043.

11. Hamilton, D. L., Chambers, D. W., & Hansen, A. (1974). Continuing education survey and three components in northern California. Journal of the California Dental Association, 3(11), 32-37.

12. Young, L. J., Speidel, T. M., & Willie, R. (1982). The effects of a continuing education course on dental hygiene practice. Journal of Dental Education, 46(4), 212-215.

13. Chambers, D. W., Hamilton, D. L., McCormick, L. P., & Swendeman, D. (1976). An investigation of behavior change in continuing dental education. Journal of Dental Education, 40(8), 546-550.

14. McClellan, T., & Cox, J. L. (1968). Description of dentist-dental assistant team training in efficient dental practice management. Journal of the American Dental Association, 76(3), 548-553.

15. Puetz, B. E., & Rytting, M. B. (1979). Evaluation of the effect of continuing education in nursing on health care. The Journal of Continuing Education in Nursing, 10(2), 22-25.

16. Chambers, D. W. (1976). How can learning experiences in continuing dental education be evaluated in relation to patient benefit? Journal of the American College of Dentists, 43(4), 238-248.

17. Stein, L. S. (1981). The effectiveness of continuing medical education: Eight research reports. Journal of Medical Education, 56(2), 103-110.

18. Ast, D. B. (1969). Qualifications of dentists under the New York State medicaid program. Journal of the American College of Dentists, 36(7), 179.

19. Bellin, L. E., & Kavaler, F. (1970). Policing publicly funded health care for poor quality, over-utilization, and fraud--the New York medicaid experience. American Journal of Public Health, 60(5), 811.

20. DeVincenzi, R. G. (1978). A practitioner's perspective: Putting a label on progress. California Dental Association Journal, 7(10), 28-29.

21. Williams, D. C. (1980). From wanting to learn to learning to want. Chicago, Illinois: AEA/USA Task Force on Voluntary Learning.

22. Cunningham, P. M., & Hawking, J. (1980). Literature review on research on MCE for professionals. Chicago, Illinois: AEA/USA Task Force on Voluntary Learning.

23. Milgrom, P., Weinstein, P., & Ratener, P. (1980). Quality assessment as a form of continuing dental education: Changing dentist clinical performance. Journal of the American Dental Association, 101(2), 258-264.

24. Sullivan, M. E. (1981). Self-assessment, mandatory continuing education, and license renewal for health professions. Lifelong Learning: The Adult Years, 4(9), 22-24, 27.

25. Keyworth, B. A. (1970). The why and how of the Minnesota continuing education law. Ohio Dental Journal, 44(5), 310-312.

26. Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. Psychometrika, 16(3), 297-334.

27. Board of Dentistry. (1981). Minnesota code of agency rules: Board of Dentistry. St. Paul, Minnesota: The State Register and Public Documents Division, Department of Administration.

28. Committee on Dental Hygiene Education and the Subcommitte on Curriculum Essentials. (1977). Curriculum guidelines for dental hygiene education: Performance standards based on task analysis and instructional objectives (4th ed.) Chicago, Illinois: American Dental Hygienists' Association.

29. Staff. (1984). Mandatory continuing professional education. Continuing Education for the Professions Newsletter, 5(1), 1.